Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

42 CFR
430.10

(Omitted
45 CFR
Part 201,
AT-70-141)

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the

DEPARTMENT OF SOCIAL ANO HEALTH SERVICES
(Single State Agency)

submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Revision:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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State/Territory: WASHINGTON

SECTION 1 SINGLE STATE AGENCY ORGANIZATION

Citation	1.1	Designation and Authority
42 CFR 431.10 AT-79-29	(a)	The Department of Social and Health Services is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this paragraph.) ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Citation		
	1.1	Designation and Authority (cont.)
Sec.1902(a) of the Act	(b)	The State agency that administered or supervised the administration of the plan approved under title X of the Act as of January 1, 1965, has been separately designated try administer or supervise the administration of that part of this plan which relates to blind individuals.

/ / Yes. The state agency so designated is _____

_____.
This agency has a separate plan covering that portion of the State plan under title XIX for which it is responsible.

/X/ Not applicable. The entire plan under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Citation 1.1 Designation and Authority (cont.)

Intergovernmental Cooperation Act of 1968

(c) Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

/ / Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.

/ / Not applicable. Waivers are no longer in effect.

/X/ Not applicable. No waivers have ever been granted.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Citation	1.1	Designation and Authority (cont.)		
42 CFR 431.10 AT-79-29		(d)	/X/	The agency named in paragraph 1.1 (a) has responsibility for all determination of eligibility for Medicaid under this plan.
			/ /	Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in ATTACHMENT 1.2-A. there is a written agreement between the agency named in paragraph 1.1 (A) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Citation	1.1	Designation and Authority (cont.)
42 CFR 431.10 AT-79-29	(e)	All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act.
	(f)	All other requirements of 42 CFR 431.10 are met.

Revision: HCFA-AT-80-38 (BPP) OMB No.: 0938-0193
May 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Citation 1.2 Organization for Administration

42 CFR 431.11
AT-79-29

(a) ATTACHMENT 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.

(b) Within the State agency, the Medical Assistance Administration has been designated as the medical assistance unit. ATTACHMENT 1.2-B contains a description of the organization and functions of the medical assistance unit and an organization chart of the unit.

(c) ATTACHMENT 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1 (a). ATTACHMENT 1.2-D contains a description of the staff designated to make such determinations and the functions they will perform.

/X/ Not applicable. Only staff of the agency named in paragraph 1.1 (a) make such determinations.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

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Citation	1.3	Statewide Operation
42 CFR 431.50 (b) AT-79-29		The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.

/X/ The plan is State administered.

/ / The plan is administered by the political subdivisions of the State and is mandatory on them.

Revision: HCFA AT-80-38 (BPP)
May 22, 1980

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Citation	1.4	State Medical Care Advisory Committee
42 CFR 431.12(b) AT-78-90		There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.
42 CFR 438.104	X	The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.

REVISION: HCFA-PM-94-3 (MB)
April 1994

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Citation 1.5 Pediatric Immunization Program

1928 of the Act

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

   a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

   b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

   c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

   d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.

   e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

   f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

   g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

REVISION: HCFA-PM-94-3 (MB)
April 1994

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Citation 1.5 Pediatric Immunization Program (cont.)

1928 of the Act

2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

/ / State Medicaid Agency

/X/ State Public Health Agency

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Citation	1.6	Managed Care
42 CFR 438	1.	General Description of the Program

a. The programs are: Healthy Options (HO), provided through contracts with Managed Care Organizations (MCOs); and a Primary Care Case Management (PCCM) program for American Indians/Alaska Natives (AI/AN), provided through contracts with tribal Indian Health Service and urban Indian clinics. Note: the acronym PCCM is used interchangeably for Primary Care Case Management as well as for the contractor for Primary Care Case Management, (i.e., Primary Care Case Managers), and should be taken in context.

b. Through a contract with the State of Washington Health Care Authority (HCA), the state also operates Medicaid managed care programs called Basic Health Plus (BH+) and the Maternity Support Program. The BH+ program is to allow Medicaid-eligible children to remain with their families who are already enrolled in Basic Health, the state-funded-only managed care program. The Maternity Support Program is to allow pregnant enrollees in Basic Health to maintain their enrollment with their MCO for the time period they are Medicaid-eligible. The HCA contracts with MCOs to provide both the state-funded-only and Medicaid programs. The BH+ and Maternity Support Program benefits are identical to HO. The BH+ and Maternity Support Program are required to meet the same federal and state requirements that HO must meet. Any state commitment described herein for HO applies also for BH+ and the Maternity Support Program.

c. All Medicaid beneficiaries described in section 3 are required to enroll in MCOs contracted for HO. Beneficiaries described in section 2b will not be mandatorily enrolled in HO or PCCM. Beneficiaries described in section 4 are excluded from HO and PCCM. Only AI/ANs, or those traditionally served by tribal or IHS clinics, may enroll in the PCCM program.

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Citation 1.6 1.Managed Care (cont'd)

42 CFR 438

d. The objectives of HO and PCCM are to reduce costs, reduce inappropriate utilization, and assure adequate access to quality health care for Medicaid beneficiaries.

e. HO and PCCM are intended to enroll Medicaid beneficiaries in MCOs or PCCMs, which will provide or authorize all primary care services and all necessary specialty services for enrollees. The MCO or PCCM is responsible for monitoring enrollees' care and their utilization of nonemergency services. Enrollees' access to emergency and family planning services are not restricted under this program.

f. The MCO or PCCM will assist enrollees in gaining access to the health care system and, on an ongoing basis, will monitor enrollees' condition, health care needs, and service delivery. The MCO or PCCM will be responsible for either providing or locating, coordinating, and monitoring all primary care and other medical and rehabilitation services on behalf of enrollees in the MCO or PCCM.

g. Enrollees under HO or PCCM will be restricted to receiving services included under the HO or PCCM through their enrolled MCO or PCCM. The enrollee's health care delivery will be managed by the MCO or PCCM. HO and PCCM programs are intended to enhance existing provider-patient relationships and to establish a relationship where there has been none. The program will also enhance continuity of care and efficient and effective service delivery.

42 CFR 438.52

h. Potential enrollees will have a choice of at least two MCOs. Enrollment is continuous so enrollees may change MCOs at any time. The State is responsible for enrollment, but the State and MCOs will cooperate in providing potential enrollees with sufficient information to make informed decisions.

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Citation 1.6 1.Managed Care (cont'd)

42 CFR 214

i. The State requires recipients to obtain services from only those providers qualified to provide Medicaid services that have not been excluded or debarred from Medicaid participation.

k. PCCM and HO are existing programs, but the state continues to actively seek stakeholder input through statewide and community standing committees which are open to MCO, PCCMs, other state and local agencies, community representatives, and Medicaid clients. When the state anticipates and implements changes to the programs, it also seeks input from its stakeholders through standing and ad hoc exchange mediums. Examples of the State's commitment to seeking stakeholder input are:

(1) The State chairs the Title XIX Advisory Committee that meets bimonthly. The committee provides an avenue for stakeholder input on all major issues concerning Title XIX, including PCCM and HO. The committee membership includes State staff, client advocates, providers, provider professional organizations, MCOs, public health organizations, and Indian tribes.

(2) Since the beginning of the Healthy Options program, the State staff responsible for day-to-day administration of the program have held standing open meetings in every region of the state. The timing of the meetings has varied from monthly to quarterly. The meetings are open to all stakeholders and are for stakeholders to voice issues, large and small, regarding Medicaid managed care.

(3) When a large change in the managed care programs is contemplated, such as the changes requested in the State's recent 1115 waiver request, the State has advertised and held facilitated, statewide meetings with stakeholders to provide information and solicit and respond to input.

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Citation 1.6 2. Managed Care (cont'd)

2. Assurances

a. Consistent with this description, the State assures that it meets applicable requirement of the following statute and regulations:

(1) Section 1903(m) of the Social Security Act (the Act) for MCOs and MCO contracts.

(2) Section 1905 (t) of the Act for PCCM and PCCM contracts.

(3) Section 1932 of the Act, including Section (a)(1)(A) for the State's option to limit freedom of choice by requiring recipients to receive their benefits through managed care organizations.

(4) 42 CFR 438 for MCOs and PCCMs.

(5) 42 CFR 434, including 42 CFR 434.6 of the general requirements for contracts.

(6) 42 CFR 438.6(c) of the regulations for payments under any risk contracts.

(7) 42 CFR 447.362 for payments under any non-risk contracts.

(8) 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in Section 1905(a)(4)(C).

(9) 45 CFR part 74 for procurement of contracts.

42 CFR 438.50

b. The State assures that it will not require the following groups to mandatorily enroll in HO. The State's Automated Client Eligibility System (ACES) and Medicaid Management Information System (MMIS) gather eligibility information and have identifiers for all categories of eligibility. Indians who are members of

Citation 1.6 2. Managed Care (cont'd)

Federally qualified tribes self-identify in the enrollment process. Specific SSI information is provided through SSA SDX. Specific Title V information is passed from the State's Department of Health. Other eligibility determinations are made by State staff and entered into ACES/MMIS. Dual-eligibles, children served under 1902(e)(3) of the Act, and title IV-E are identified in the enrollment process or when they become eligible for those programs and entered into the ACES/MMIS systems, which have coding which identifies them.

(1) Medicare eligibles. Medicare eligibles are not eligible to enroll in HO.

(2) Indians who are members of Federally recognized tribes. Indians who are members of Federally recognized tribes may choose to be in the State's fee-for-service program or may voluntarily enroll in HO if they are not also members of an eligibility group that is otherwise excluded from HO enrollment.

(3) Individuals receiving SSI benefits under Title XVI. Individuals receiving SSI benefits under Title XVI are not eligible to enroll in HO.

(4) Children under 19 years of age who are:

(A) Receiving SSI benefits under title XVI. Children receiving services under Title XVI are not eligible to enroll in HO.

(B) Eligible under section 1902(e)(3) of the Act. Children receiving services under section 1902(e)(3) of the Act are not eligible to enroll in HO.

(C) In foster care or other out-of-home placement. Children receiving services in foster care or other out-of-home placement are not eligible to enroll in HO.

Citation 1.6 2. Managed Care (cont'd)

(D) Receiving foster care or adoption assistance. Children receiving foster care or adoption assistance are not eligible to enroll in HO.

(E) Receiving services through a family-centered, community-based coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs. Children receiving services through Title V may voluntarily enroll in HO.

c. It is the State's intent that HO be available throughout the State. HO will be implemented statewide. Mandatory enrollment provisions will not be implemented unless a choice of at least two MCOs is available.

42 CFR 438.58

d. The State has safeguards in effect to guard against conflict of interest on the part of employees of the State and its agents.

e. Through reporting from the State's Department of Health (DOH), the State identifies children receiving family-centered, community-based services through a coordinated-care system administered by DOH and provided through local health departments. The services are funded under section 501(a)(1)(D) of title V. Children so identified may request exemption/disenrollment from HO at any time without cause by contacting the State.

3. Included Populations

a. Section 1931 Children and Related Poverty Level Populations (TANF/AFDC)

b. Section 1931 Adults and Related Poverty Level Populations, including pregnant women (TANF/AFDC).

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Citation 1.6 4. Managed Care (cont'd)

4. Excluded Populations

a. Persons having Medicare coverage

b. Persons receiving services through the State's Title XXI SCHIP program

c. Persons with other health insurance, which the State considers comparable to HO coverage.

d. See also populations which are identified as excluded in 1.6, 2.b. of this section.

42 CFR 438.50

5. Enrollment and Disenrollment

a. In accordance with 42 CFR 438.52, all recipients will be given the opportunity to choose from at least two MCOs. The State will not mandatorily enroll recipients if two MCOs are not available.

42 CFR 438.50

b. The State will have the following process for default HO enrollment for potential enrollees who do not choose a MCO:

The State will determine the total capacity of all MCOs receiving assignments in each service area. Each MCO's capacity in each service area will be divided by the total capacity of all MCOs receiving assignments in each service area. The result of the calculation will be multiplied by the total of the households to be assigned. The State will assign the number of households determined by the calculation to the Contractor. The State will not make any assignments of enrollees to an MCO in a service area if the MCOs enrollment, when the State calculates assignments, is ninety percent (90%) or more of its capacity in that service area.

MCOs may choose not to receive assignments or limit assignments in any service area by so notifying the State in writing. The State reserves the right to make no assignments, or to withhold or limit assignments to

Citation 1.6 5. Managed Care (cont'd)

any MCO when it is in the best interest of the State. If either the MCO or the State limits assignments as described herein, the Contractor's capacity, only for the purposes of the calculation of assignments, will be that limit.

Assigned enrollees are notified by mail by the State of their assignment and have at least ten (10) days to choose a different MCO or PCCM.

c. The State collects information about all newly created managed care segments. At the time monthly health plan premiums are paid, the State looks at each new enrollee to see how they were enrolled into HO.

The "overall" rate looks at all new managed care enrollment segments to determine how they got to their plan. An "S" (for "selected") or an "A" (for "assigned") is attached to each HO enrollment segment in MMIS. The State looks at the total number of enrollees with a new segment and calculates the percentage of those who selected a plan and those who were assigned. The calculation includes enrollees who changed from one plan to another, who are a new family member, and who have had a short break in coverage.

The "newly eligible" rate looks at the date a client's information comes to MMIS from ACES. If there has been a break in service that is greater than 3 months, the State looks at the "A" or "S" indicator on their managed care enrollment segment to determine how they got to the plan. The State then takes the number

Citation 1.6 5. Managed Care (cont'd)

of "newly eligible" people and looks at the percentages of assignments and voluntary selections for the rate.

The rate of voluntary vs. assigned is examined and trended over time and has, and may again if necessary, become the focus of a quality improvement effort if the State finds the percentage or increasing trend in "A" assignments disturbing. After the prior successful quality improvement effort, the trend would be considered disturbing if it has any long-term (measured over a full year) significant increase.

42 CFR 438.50

d. Through the MMIS, State has procedures in place to identify the prior MCO, and re-enrolls an enrollee who is terminated from an MCO solely because the enrollee lost his or her Medicaid eligibility with that prior MCO when the enrollee is subsequently determined to be Medicaid- and HO-eligible.

e. If a recipient has a prior provider relationship that they wish to maintain, the State will, to the best of its abilities, assist the recipient in choosing an MCO that will maintain this relationship. The potential enrollee can identify the provider on the enrollment form or through telephone contact with the State.

f. HO enrollees may change MCOs at any time. AI/AN PCCM enrollees may switch to HO or FFS at any time. Non-AI/AN PCCM enrollees may switch to HO at any time.

g. MCOs and PCCMs will not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of services.

h. MCOs and PCCMs will not terminate enrollment because of an adverse change in the recipient's health.

i. In accordance with 42 CFR 438.56(d)(2), if an enrollee's needs cannot be reasonably met by HO, the enrollee may request, and State may grant, an

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Citation 1.6 5. Managed Care (cont'd)

exemption from mandatory participation in HO. Reasons for exemption include medical needs which cannot be met by managed care, homelessness, and language barriers. Participation in PCCM is not mandatory.

j. At the time of enrollment, the State will inform potential enrollees of their disenrollment and exemption rights.

k. An enrollee will be allowed to choose his or her health professional in the MCO and PCCM to the extent possible and appropriate and may change his or her health professional anytime without cause.

42 CFR 438.50

l. Enrollees will have access to specialists to the extent possible and appropriate, and female enrollees will have direct access to any women's health specialist within the MCO's network. Female enrollees in PCCMs have access to any FFS women's health specialist.

m. Since the State's managed care program is long standing, all of the current contractors are traditional Medicaid providers and the State makes its best efforts to preserve the State's and its recipients' relationship with those providers.

n. Recipients who are already enrolled with an MCO or PCCM will be given priority to continue enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment.

o. Tribal members will be enrolled in the appropriate tribal or Indian Health Service (IHS) PCCM, but may choose either the HO or FFS programs prior to or at any time after PCCM enrollment.

p. The State allows the MCOs and PCCMs to request and be granted the disenrollment of enrollees only if the

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Citation 1.6 5. Managed Care (cont'd)

42 CFR 438

enrollee poses an unreasonable threat to staff or other patients.

q. HO enrollees may change plans at any time, with the change to become effective the next month if the request is before enrollment cut-off and the month following that month if it is after cut-off. Enrollment is for whole months for both HO and PCCM.

r. Potential enrollees or current enrollees, including those whose enrollment is voluntary, may request exemption from managed care in writing or by telephone through the Exception Case Management section of the State's Medical Assistance Administration. Those individuals for whom enrollment is not mandatory are removed upon request.

6. Payment/Contracts

a. The contracts with MCOs for HO are comprehensive risk contracts.

b. The contracts with MCOs for HO provide for capitation payments for services.

42 CFR 438

c. Capitation payments meet the requirements of 42 CFR 438.6.

d. Contracts for MCO services for HO will be competitively procured or will be available to all qualified MCOs.

e. The contractors for PCCM are federally-recognized tribes and IHS or urban Indian clinics. PCCMs are paid a $3.00 per-member-per-month (PMPM) case management fee. Services provided through PCCM are paid for FFS, including the IHS encounter rate or the FQHC encounter rate if the PCCM is an IHS clinic or an FQHC.

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Citation 1.6 6.Managed Care (cont'd)

f. The service areas for each MCO are identified in contract.

g. HO Non-Covered Services, described in section 7, are not included in any calculation of capitation payments.

h. The populations included/excluded from HO and PCCM are described in sections 3 and 4.

i. Neither MCOs nor PCCMs are paid any bonuses or incentives.

7. Covered/Non-Covered Services

a. PCCMs and MCOs will cover only those services described in this title XIX, Medicaid State Plan.

b. Services covered/non-covered by MCOs and services covered/non-covered by the State FFS will be described in MCO HO contracts and, for enrollees and potential enrollees, in information provided by the State and/or MCO. Pages 9u through 9y describe services covered by MCOs vs. FFS. The following FFS program services are excluded from HO:

(1) Chiropractic, except for EPSDT

(2) Day treatment services

(3) Dental services

(4) Detoxification (except for acute alcohol poisoning)

(5) Developmental disability services

(6) Education agency services

(7) Eyeglass frames, lenses, and fabrication

(8) First Steps Maternity Case Management and Maternity Support

(9) Gastroplasty

(10) Hearing Aids

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Citation 1.6 7. Managed Care (cont'd)

(11) Mental health services beyond a limited benefit described in contract

(12) Neurodevelopmental services paid for through the State's Department of Health

(13) Non-emergency transportation

(14) Parital hospitalization

(15) Personal care

(16) Protease inhibitors

(17) Skilled nursing facility services, except when provided as a short-term hospital alternative

(18) Sterilizations for those under age 21 or not meeting Federal requirements

(19) Substance abuse treatment

c. PCCM provides identical services as are provided in the Medicaid FFS program

8. Mandates

Qualifications and requirements for MCOs and PCCMs will be noted in State/MCO HO and State/PCCM contracts. Those contracts will incorporate all Federal and State requirements for such programs and will include, but not be limited to, the following mandates:

a. An MCO or PCCM will be a Medicaid-qualified provider and may not use persons/organizations excluded from the provision of Medicaid services in the provision of HO services.

42 CFR 438

b. The MCO will have a State-approved grievance process. The State provides the system for PCCM grievances.

Citation 1.6 8. Managed Care (cont'd)

c. The MCO or PCCM will provide or, for PCCMs, arrange for the provision of comprehensive primary health care services to all eligible Medicaid recipients who choose or are assigned to the MCO or PCCM.

d. The MCO or PCCM will refer enrollees for specialty care, hospital care, or other services when medically necessary.

e. The MCO or PCCM will make telephone access available 24-hours a day, 7 days a week. This access is to a live voice (an employee of the MCO or a representative) or an answering machine. During non-office hours, the answering machine will immediately page an on-call medical professional to make referrals for non-emergency services, handle medical problems, or give information about accessing services.

f. The MCO or PCCM will not refuse an assignment or disenroll an enrollee or otherwise discriminate against an enrollee solely on the basis of age, sex, physical or mental disability, national origin (except for tribal origin), or type of illness or condition, except when that illness or condition can be better treated by another provider type.

g. All subcontractors will be required to meet all pertinent requirements as those that are in effect for the MCO or PCCM.

h. The MCO will be licensed by the State of Washington, Office of the Insurance Commissioner (OIC) in order to ensure financial stability (solvency) and compliance with regulations. PCCMs will be Federally recognized tribes, IHS clinics, or urban Indian clinics.

9. Additional Requirements

a. Any marketing materials available for distribution under the Act and State statutes will be provided to the State for its review and approval to assure that the requirements of the Act and such statutes are met.

Citation 1.6 9. Managed Care (cont'd)

b. The MCO or PCCM will certify that no recipient will be held liable for any MCO debt as the result of insolvency or for services the State will not pay for.

c. The MCO or PCCM will include safeguards against fraud and abuse, as provided in State and Federal statutes.

d. The information provided to HO and PCCM enrollees will be in compliance with 42 CFR 483.10(i).

e. Through its ongoing day-to-day monitoring process and annual contract compliance review, the State monitors MCO and PCCM compliance with applicable provisions of 42 CFR 438 Subpart I.

f. The contracts with MCOs or PCCMs will have provisions implementing the applicable provisions of 42 CFR 438, subpart I.

10. FQHC and RHC Services

Enrollees will be provided reasonable access to FQHC and RHC services.

11. Process for Enrollment in an MCO

The following process is in effect for recipient enrollment in MCOs:

a. The State will provide the recipient with all of the following:

42 CFR 438

(1) A packet explaining the program and comparing MCOs in a chart-like format including benefits, services covered and not covered, and quality and performance indicators. Quality and performance indicators include disenrollment rates and enrollee satisfaction.

(2) A form for enrollment in the plan and selection of a plan.

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Citation 1.6 11. Managed Care (cont'd)

(3) A list of MCOs serving the recipient's geographical service area.

(4) A toll-free number that can be used to pose questions by telephone.

(5) Enrollee rights and responsibilities.

(6) Information explaining the grievance system.

(7) Information on how to obtain Medicaid services not covered by the MCO.

b. All materials will be translated into languages other than English as necessary and will be in an easily understood format.

c. Each recipient will notify the State by mail, fax, telephone, or in person, of his or her choice of MCOs.

d. If the recipient does not choose an MCO, the State will assign the recipient to an MCO and notify the recipient of the assignment.

e. The MCO will be informed electronically of the recipient's enrollment in that MCO.

f. The recipient will be notified of enrollment and issued an identification card.

42 CFR 438

g. Additionally, each MCO will provide the following information within a reasonable time period after notice of enrollment, and to any potential enrollee upon request:

(1) Benefits offered, the amount, duration, and scope of benefits and services available.

(2) Procedures for obtaining services.

(3) Names, locations and non-English languages spoken for current network providers, including those providers not accepting new patients.

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(4) Any restrictions on freedom of choice.

(5) The extent to which there are any restrictions concerning out-of-network providers.

(6) Policies for specialty care and services not furnished by the primary care providers.

(7) Grievance process.

(8) Other information as may required by Federal or State statute, rule, or policy.

42 CFR Subpart D

12. Monitoring of Quality of Health Care and Services, Including Access

HO Quality of Health Care and Services and enrollees' access to care will be monitored as part of each MCO's internal QIP, through the annual quality review of MCOs by the State through required internal and external quality review. PCCMs are monitored through the FFS program monitoring and are required to cooperate with State quality monitoring. Those activities are described in State/MCO Healthy Options contracts, PCCM contracts and the State quality strategy.

42 CFR 438

13. Access to Care

a. Recipients may choose any of the participating MCOs in the service areas. AI/ANs will be enrolled with a tribal, IHS, or urban Indian clinic unless they choose HO or FFS. For HO, the State will make available an MCO-certified service area map that is updated each contracting period. In addition, as per 42 CFR 434.29, within an MCO, each Medicaid enrollee has a choice of health professional to the extent possible and feasible.

b. The same range and amount of services that are available under the Medicaid fee-for-service program are available for enrollees covered under the HO and PCCM programs.

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c. State-specified access standards for distances and travel miles to obtain services for recipients under the HO program have been established.

d. Primary care and health education are provided to enrollees by a chosen or assigned MCO or PCCM. This fosters continuity of care and improved provider/patient relationships.

e. Pre-authorization is precluded for emergency/post stabilization and family planning services under the HO and PCCM programs.

42 CFR 438.206

f. MCOs and PCCMs are required to provide or arrange for coverage 24 hours a day, 7 days a week.

g. HO and PCCM enrollees have an equivalent or better appeals system as is in effect under the Medicaid fee-for-service program. Recipients have available a formal appeals process under 42 CFR Part 438, Subpart F.

h. The State assures that State-determined access standards are monitored on an on-going basis.

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14. Services Covered by MCOs vs. FFS

Service **(1)**	**State Plan Approved** **(2)**	**1915(b)(3) Waiver Services** **(3)**	**MCO/PHP Capitated Reimburse-ment** **(4)**	**Fee-for-Service Reimburse-ment** **(5)**	**Fee-for-Service Reimbursement impacted by MCO/PHP** **(6)**
Day Treatment Services	X			X	
Dental	X			X	
Detoxification	X			X	
Developmental Disabilities Services (please explain) *(ICF/MR) Developmentally disabled clients receive medical services fee for service through the ICF/MR*	X			X	
Durable Medical Equipment *(Except Hearing Aides)*	X		X		
Education Agency Services *(School-Based Services for Special Education Prog.)*	X			X	
Emergency Services	X		X		
EPSDT *(Including Chiropractic)*	X		X		

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1.6 14. Managed Care (cont'd)

Service **(1)**	**State Plan Approved** **(2)**	**1915(b)(3) Waiver Services** **(3)**	**MCO/PHP Capitated Reimburse-ment** **(4)**	**Fee-for-Service Reimburse-ment** **(5)**	**Fee-for-Service Reimbursement impacted by MCO/PHP** **(6)**
Family Planning Services. *Note: HO members may seek family planning services through the plan, or may self-refer to the local health dept. or family planning agency.*	X		X	X	
Federally Qualified Health Center Services	X		X		
Hearing Aids	X			X	
Home Health	X		X		
Hospice	X		X		
Inpatient Hospital - Psych	X			X	
Inpatient Hospital	X		X		
Immunizations – *HO members may receive immunizations from their PCP, or self-refer to their local health dept*.	X		X	X	
Maternity Case Management/Maternit y Support Services	X		X	X	
Lab and x-ray	X		X		

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1.6 14. Managed Care (cont'd)

Service **(1)**	**State Plan Approved** **(2)**	**1915(b)(3) Waiver Services** **(3)**	**MCO/PHP Capitated Reimburse-ment** **(4)**	**Fee-for-Service Reimburse-ment** **(5)**	**Fee-for-Service Reimbursement impacted by MCO/PHP** **(6)**
Mental Health Services *The 2001 HO contract requires 1 evaluation per year for adults and as necessary for children; also, medication mgt. and 12 visits to m.h. professional are covered. Clients may receive services from plan or self- refer to community mental health.*	X		X	X	
Nurse midwife	X		X		
Nurse practitioner	X		X		
Nursing Facility	X			X	
Obstetrical services	X		X		
Occupational therapy	X		X		
Other fee-for-service services	X			X	
Other Outpatient Services -- Please Specify					
Other Psych Practitioner					
Outpatient Hospital - All Other	X		X		

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1.6 14. Managed Care (cont'd)

Service **(1)**	**State Plan Approved** **(2)**	**1915(b)(3) Waiver Services** **(3)**	**MCO/PHP Capitated Reimburse-ment** **(4)**	**Fee-for-Service Reimburse-ment** **(5)**	**Fee-for-Service Reimbursement impacted by MCO/PHP** **(6)**
Outpatient Hospital - Lab & X-ray	X		X		
Partial Hospitalization	X			X	
Personal Care	X			X	
Pharmacy	X		X		
Physical Therapy	X		X		
Physician	X		X		
Private duty nursing	X		X		
Prof. & Clinic and other Lab and X-ray	X		X		
Psychologist *(Service may be covered either by ffs or through MCO depending on referral process)*	X		X	X	
Rehabilitation Treatment Services	X		X		
Respiratory care	X		X		
Rural Health Clinic	X		X		
Speech Therapy	X		X		
Substance Abuse Treatment Services	X			X	

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Service **(1)**	**State Plan Approved** **(2)**	**1915(b)(3) Waiver Services** **(3)**	**MCO/PHP Capitated Reimburse-ment** **(4)**	**Fee-for-Service Reimburse-ment** **(5)**	**Fee-for-Service Reimbursement impacted by MCO/PHP** **(6)**
Testing for sexually-transmitted diseases (STDs) *NOTE: HO members may receive these services through the plan or may self-refer to the local health dept.*	X		X	X	
Transportation – Emergency	X		X		
Transportation - Non-emergency	X			X	
Vision Exams and Glasses *(Vision exams covered by MCOs, hardware covered ffs)*	X		X	X	
Other -- Please specify					
Other Pharmacy Services -- Please specify (e.g., Health Drugs)					
Other Mental Health Services – Please Specify					
Other Inpatient Services – Please Specify					